# ***OVERPAYMENT REFUND REQUEST***

Date of Request: ____________________

Account Number: ______________________________ Payment Date: ____________________

Account Holder Name: __________________________

Credit Card Account Holder Name: ______________________

Service Address: ______________________________

Refunds by check should be mailed to:

______________________________________________
Street City State Zip

Payment Type:
- ☐ Cash
- ☐ Check
- ☐ EFT
- ☐ MasterCard
- ☐ Visa

(Check One)

Payment Amount : $ ______________

Last four digits of credit card used: ______________

Refund Amount: $ ______________ Or, original check number used: ______________

REASON FOR REFUND REQUEST:

__________________________________________

Please read each of the following statements and check the box to the left to indicate that you have read and agree to the terms of this refund request. **Your refund will not be processed unless all boxes are checked.**

☐ I understand my request may alter the amount due on my current statement and or next statement period.

☐ I understand that this request will be calculated based on the information I have provided. I also understand that I am responsible for the repayment of all charges that may be identified at a later date.

My signature below indicates that I have read and agree to the terms and conditions of the request.

Signature: ____________________________________________